3 February 2020

The Hon. Tony Pagone QC
Chair, Royal Commission into Aged Care Quality and Safety
GPO Box 1151

Adelaide SA 5001

Dear Mr Pagone

RE: Consultation on the Aged Care Program Redesign

The Society of Hospital Pharmacists of Australia is the national professional organisation for more than 5,000 pharmacists, pharmacists in training, pharmacy technicians and associates working across Australia's health system. SHPA is committed to facilitating the safe and effective use of medicines, which is the core business of pharmacists, especially in hospitals.

SHPA welcomes the opportunity to provide feedback on the Aged Care Program Redesign proposed by the Royal Commission into Aged Care Quality and Safety. SHPA supports the need for urgent system-wide reform of aged care in Australia and believes the principles for a new system outlined in the consultation paper are patient-centric and well informed.

The focus of SHPA's submission is on the redesign of the aged care system to prevent medication-related harm and support the safe and quality use of medicines in older people. The use of medicines in aged care is highly prevalent and complex as many older people have several chronic health conditions requiring treatment with different medicines. Pharmacy practice is well developed in this space, with the *SHPA Standard of Practice in Geriatric Medicine for Pharmacy Services*, a resource detailing best practice provision of clinical pharmacy services for older people in hospitals, residential aged care facilities (RACF), transition care services and in the community, pending imminent publication in coming weeks. SHPA will be happy to supply a copy to the Royal Commission when available.

Quality Use of Medicines and Medicines Safety is a National Health Priority Area with recent studies reporting 250,000 hospital admissions per annum attributed to medication-related problems[1]. Medication errors have a disproportionate impact on Australians aged 65 years and over, accounting for 20-30% of hospital admissions[2].

Research indicates that 91% of aged care residents take at least five regular medicines per day[3] however only 29% of residents in aged care facilities received medication management reviews during 2017-18[4]. Data indicates 40-50% of residents in aged care facilities are prescribed inappropriate medications[2] and that comprehensive medication reviews identify 2.7-3.9 medication-related problems per resident[5]. The overall high rate of medicines use, some of which is inappropriate and unsafe, coupled with the lack of pharmacist clinical services, puts aged care residents at high risk of medication-related harm such as falls, avoidable hospitalisations or inappropriate use of antipsychotics for chemical restraint.

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SHPA has made the following key recommendations in the attached submission, detailing interventions to be considered in the Aged Care Program Redesign process, that will improve the safe use of medicines for older people in Australia:

1. Upon entry to the aged care system, the basic screening process must specifically assess an older person's risk of medication-related harm to identify the appropriate level of care and services required for each individual.
2. Geriatric Medicine Pharmacists must be included in the multi-disciplinary team conducting comprehensive assessments at entry to the aged care system.
3. Health practitioners and services (including home nursing services) supporting older people living at home, must have access to clinical pharmacists to aid with medicine management.
4. Restorative care services must refer older people at risk of medication-related harms, for clinical pharmacist reviews at key transition points.
5. Interim medication administration charts should be used for older people discharged to Residential Aged Care Facilities (RACFs) and home care settings.
6. All Home Care Packages must include medicine reviews.
7. Pharmacists must be embedded in all Residential Aged Care Facility (RACF) teams to improve health outcomes in older people and minimise the use of chemical restraint.

SHPA notes that there is currently a lack of Medicines Leadership to steer the Australian healthcare system's pharmacy and medicine policy and ensure that the appropriate advice, programs and resources are being developed to maximise the Quality Use of Medicines Safety amidst the changing face of the aged care system. As stated in our *2020-21 Federal Pre-budged submission*[6], SHPA supports the establishment of a Medicines Leadership Advisory Council to advise and support the Federal Government's initiatives on Medication Safety and Quality Use of Medicines.

If you have any queries or would like to discuss our submission further, please do not hesitate to contact Johanna de Wever, General Manager, Advocacy and Leadership on jdewever@shpa.org.au.

Yours sincerely,

Kristin Michaels

Chief Executive

SHPA SUBMISSION TO THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY: AGED CARE PROGRAM REDESIGN

Information, assessment and system navigation

1. Upon entry to the aged care system the basic screening process must specifically assess an older person's risk of medication-related harm to identify the appropriate level of care and services required for each individual.

Every individual accessing aged care services in Australia should be screened for risks of medication-related harm and measures should be put in place to mitigate harm and prevent rapid decline in health, ultimately improving the person's overall quality of life and serving as long-term cost-saving interventions.

Older people have a high prevalence of multiple chronic health conditions and are often taking multiple medicines. They have an increased susceptibility to drug interactions and harmful side effects of medicines. The way their body interacts with a medicine is complex and impacted by many factors, such as liver and kidney function. As a result, medication errors have a disproportionate impact on Australians aged 65 years and over, accounting for 20-30% of hospital admissions[2].Older people also have higher prevalence of impaired functional capacity and cognitive decline impacting on their ability to manage complex medicines regimens.

Entry into the aged care system is the opportune time to screen for risk of medication-related harm. The inappropriate use of medicines can be the sole factor that leads to the rapid decline of an older person resulting in hospitalisation, displacement from their home environment and ultimately, leading to an overall poorer quality of life whilst burdening the health system and accruing unnecessary costs.

A medication management algorithm can be used to calculate an older person's risk of medication-related harm. SHPA has developed a list of risk factors to guide assessment of medication-related risks that can be used to support this screening process, please see Appendix A.

The results obtained from this medicines screening process should be considered by care finders when linking people to services that meet their needs, this may include an assessment for a Dose Administration Aid (DAA) by a health care professional. Older people in the entry-level support stream who have difficulty self-administering their medicines due to their complexity, may benefit from medication management interventions such as DAAs to ensure they do not double-up on their medicines and risk overdose or underdosing. A DAA is a packaging system for organising doses of medicines according to the time of administration, a useful tool to be used in a coordinated approach to medication management. Other people in this stream may require a medication review to be conducted by a pharmacist. People identified as being at potential risk of harms associated with their use of medicines should be flagged for a medication review to be conducted in the community setting through a Home Medicines Review (HMR) by an Accredited Pharmacist.

Individuals identified through the medicines screening process as high risk should be referred for a comprehensive multi-disciplinary team assessment which includes a Geriatric Medicine Pharmacist, as this may impact the level of care they require. Geriatric Medicine Pharmacists work almost exclusively with older people and have expertise in geriatric medicine, many having attained further education in this area. Pharmacy practice is well developed in this space, with the *SHPA Standard of Practice in Geriatric Medicine for Pharmacy Services*, a resource detailing best practice provision of clinical pharmacy services for older people in hospitals, residential aged care facilities (RACF), transition care services and in the community, pending imminent publication in coming weeks.

2. **Geriatric Medicine Pharmacists must be included in the multi-disciplinary team conducting comprehensive assessments at entry to the aged care system.**

Access to clinical pharmacy services for older people is limited, leaving patients at risk of adverse medication reactions and other medication-related harms including cognitive impairment, falls, and unplanned hospital admissions[7]. A preventive health approach would ensure people at high risk of medication-related harms are being identified and reviewed by a pharmacist with expertise in geriatric medicine, as part of a multi-disciplinary team at the point of entry to the aged care system. A review of antipsychotics used, and the medicines taken to manage Behavioural and Psychological Symptoms of Dementia (BPSD), would assess the appropriateness of the prescribed medicines and ensure there is a clear plan to cease or wean where suitable. This process would reduce the person's risk of long-term medication-related problems and risk of chemical restraint. Detecting and managing these problems early on may support those who would otherwise have required a high level of care, to live at home.

3. **Health practitioners and services (including home nursing services) supporting older people living at home, must have access to clinical pharmacists to aid with medicine management.**

Research indicates that nearly 50% of aged care nurse home visits are in relation to medication management issues. Pharmacists are medication experts and when involved both directly and indirectly with the client's care, they have potential to significantly reduce the risks of adverse medication events. A Visiting Pharmacist (ViP) study conducted in 2014-15 created positive outcomes and has influenced changes in medication practice. Evidence indicated a return on investment of $1.54 for every $1 spent on the ViP clinical pharmacy model[8]. SHPA believes this is a cost-effective model of care that supports better patient outcomes.

Clinical pharmacists review a person's medicine use to identify polypharmacy, adverse drug reactions and opportunities for de-prescribing. A clinical pharmacist will also spend time discussing a patient's medicine use in more detail to ensure they are being used correctly and prevent future errors.

Investment Stream

4. **Restorative care services must refer older people at risk of medication-related harms, for clinical pharmacist reviews at key transition points.**

People receiving restorative care would significantly benefit from a medicine review to ensure changes made to their medicines and physical/cognitive impacts of the illness/accident/surgery has not impaired their ability to continue taking their prescribed medicines as intended. Transitions between care settings and changes to an older person's care needs are associated with high risk of adverse drug events and indicate the need for a timely clinical pharmacist review. Investments in promoting independence and reducing medication-related harm when transitioning between care settings, is an essential element of restorative care.

5. **Interim medication administration charts should be used for older people discharged to Residential Aged Care Facilities (RACFs) and home care settings.**

Older people who are discharged from hospital to RACFs or home care settings will have RACF staff or community nurses supporting their medication management and will usually require medication administration orders to continue therapy. Interim medication administration charts provided at discharged to RACFs and home care settings significantly reduces the incidence of medication administration delays and errors, which are common during the first 24-72 hours post discharge, and hence prevents avoidable hospital readmissions. A practical and simple improvement, interim medication administration charts also eliminate the need for urgent general practitioner or locum doctor attendance on the day of discharge to prepare a medication chart and ensure continuity of care, as seen in the findings of the MedGap Study[9]. SHPA

members have identified this as a significant medication safety intervention. Some states and territories may require regulatory changes or clinician education to implement this change to medical and nursing practice.

Care Stream

6. All Home Care Packages must include medicine reviews.

The health and economic benefits of medicine reviews conducted by Accredited Pharmacists are well established with studies indicating that comprehensive medicine reviews identify 2.7-3.9 medication-related problems per aged care resident[5]. In community and residential aged care settings, it is recommended that a comprehensive interdisciplinary medication review occurs at least once every 12 months[10].

Given the high medicine use reported among older people, and the short duration necessary for many medicines initiated during an acute stay, deprescribing is an essential part of optimal care for older people. Literature notes that many triggers for deprescribing can only be identified by a medicine review[11] however studies of Home Medicine Review (HMR) uptake have found that only 5-10% of older people discharged from hospital who are referred to an Aged Care Assessment Service (ACAS) or a community nursing service or who reside in supported accommodation, receive an HMR[11].

Referral to a home nursing service should include a comprehensive medicine review conducted by an Accredited Pharmacist as this indicates a decline in a person's functional capacity, which may be related to medicines or may impact on their ability to manage their medicines[12,13].

Whilst there are currently two funding streams for medicine reviews conducted in the home setting, Community Pharmacy Agreement (CPA)-funded medicine management programs such as HMRs and state-funded hospital outreach programs such as Hospital Admission Risk Program (HARP), these services have limited reach to older people living at home.

Embedding medicine reviews in Home Care Packages would promote wider utilisation of the service resulting in better medication management and health outcomes for older people, whilst saving costs through deprescribing of unnecessary medicines and preventing hospitalisation due to falls or adverse drug events.

7. Pharmacists must be embedded in all Residential Aged Care Facility (RACF) teams to improve health outcomes in older people and minimise the use of chemical restraint.

SHPA agrees that the current packages and residential aged care programs designed to care for older people requiring personal care, nursing care and allied health services support low levels of clinical staff which significantly impact their health and quality of care provided. Quality health care should be equitable to all older people in the aged care system, regardless of setting.

As iterated in SHPA's previous submission to the Royal Commission last year, SHPA recommends increasing access to clinical pharmacy services for aged care residents so Geriatric Medicine Pharmacists can identify and manage medication-related issues and reduce harm. Access to clinical pharmacy services for older people in RACFs is limited leaving patients at risk of adverse medication reactions and other medication-related harms including cognitive impairment, falls, and unplanned hospital admissions[7].

The current provision of clinical pharmacy services in the form of federally funded programs such as the Residential Medication Management Review (RMMR) and Home Medicines Review (HMR) does not foster a culture of medication safety in RACFs as the pharmacist spends little time at the RACF, and it is difficult for pharmacist service providers to detect and address medication-related issues and collaborate with medical practitioners to implement recommendations.

Having an integrated or onsite Geriatric Medicine Pharmacist provides a solution to improving the quality use of medicines in this setting and provides equity of access to regular medication review and medicines optimisation for aged care residents. This service might be best supported by a funding model where people receiving care in residential settings would have nursing and allied health costs built into their care funding as proposed in this consultation paper.

The role of the Geriatric Medicine Pharmacist should include delivery of clinical pharmacy services to individual patients, liaison with families and caregivers, involvement in development of policies, procedures, guidelines and resources, comment on medicine formulary issues with relevance to older people, the provision of educational programs and training for healthcare professionals as well as quality improvement activities and research related to medication management. Pharmacists with expertise in geriatric medicine should be a point of contact and provide advice for medication-related enquiries from families and caregivers of residents, other pharmacists and health professionals within the RACF.

The Royal Commission into Aged Care Quality and Safety interim report identified over-reliance on chemical restraint in aged care as one of the three action areas. Geriatric Medicine Pharmacists are uniquely positioned to determine if antipsychotic medicines' prescribing is appropriate and in accordance with professional or government guidelines, and thus are able to determine if they are being used therapeutically or for chemical restraint. Embedded into RACF, Geriatric Medicine Pharmacists would play a significant part in minimising chemical restraint through regular audits and quality improvement activities as part of their Quality Use of Medicines (QUM) role at a facility level. Fundamentally, embedding Geriatric Medicine Pharmacists in RACFs will improve the quality of life of older people and ultimately minimise the use of chemical restraint in vulnerable members of our community.

Appendix A

Risk factors to guide assessment of medication-related harm[14]

Consumer-specific risk factors	Higher-risk consumer groups	High-risk medicines
• recent medicine-related problem • have suboptimal response to treatment with medicines • have multiple chronic conditions or co-morbidities • are suspected or known to be non-adherent with their medicines • have clinically significant changes to their medicines or treatment plans within the last 3 months • recent attendance to emergency department for medicine-related problem • recent hospital admission for medicine-related problem • multiple presentations or admissions to hospital or healthcare organisation in past 12 months or unplanned readmission with 28 days of discharge	• aged 65 years or older • take 5 or more medicines • take more than 12 doses of medicines per day • have difficulty managing their medicines because of literacy or language difficulties • have difficulty managing their medicines because of dexterity problems, impaired sight or cannot read medicine labels • have difficulty managing their medicines because of confusion / dementia or other cognitive difficulties • have swallowing difficulties or require medicines to be administered through an enteral feeding tube (e.g. PEG) that requires alteration to how medicines are administered • have impaired renal or hepatic function • have problems using medication delivery devices or require adherence aid • is classified as obese class 2 or 3 i.e. BMI > 35 • patients who are isolated with limited capacity to self-manage • have multiple prescribers for their medicines • does not have a regular GP	• insulins and / or oral hypoglycaemic medicines • opioid analgesics • immune suppressant therapy • anticonvulsants • anticoagulants and antithrombotics • cytotoxic chemotherapy • medicines that require therapeutic monitoring, or specific biochemistry or haematology monitoring (e.g. digoxin, clozapine, antiretrovirals used in HIV/AIDS) • intravenous potassium • aminoglycosides or vancomycin • non-steroidal anti-inflammatory drugs (NSAIDS) • beta blockers

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